UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

ALBERT CHAVARRIA	**CIVIL ACTION**
VERSUS	**NO. 13–4712**
METROPOLITAN LIFE INSURANCE COMPANY	**SECTION "H" (4)**

ORDER AND REASONS

Before the Court are Cross-Motions for Summary Judgment (Docs. 24 & 25). For the following reasons, Plaintiff's Motion is GRANTED and Defendant's Motion is DENIED. The Court will enter final judgment in favor of Plaintiff.

BACKGROUND

Plaintiff filed this suit seeking reversal of the denial of long-term disability benefits under an employee disability benefit plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA").[1] Defendant is the administrator of the plan.

[1] 29 U.S.C. §§ 1001–1461.

Plaintiff was employed by DHH Investments as an automobile body repairman ("bodyman"). As part of his employment, Plaintiff participated in a disability benefits plan. Defendant funded the plan through an insurance policy it sold to Plaintiff's employer. Defendant also was responsible for all benefits determinations.

In October of 2009, Plaintiff was awarded short-term disability benefits on the basis of an inguinal hernia. He was paid benefits until May of 2010, the maximum duration available under the plan. In May of 2010, Defendant opened a new claim on Plaintiff's behalf for long-term disability benefits and Defendant paid these benefits from May of 2010 until April 4, 2012. On April 5, 2012, Defendant contacted Plaintiff and informed him that he no longer met the plan's definition of disabled and that his benefits would be terminated effective April 4, 2012. Plaintiff appealed this decision through Defendant's administrative review process. After receiving a final decision denying his claim for benefits, Plaintiff filed the instant suit.

LEGAL STANDARD

"The summary judgment standard for ERISA claims is 'unique,' because the Court acts in an appellate capacity reviewing the decisions of the administrator of the plan."[2] "Where the decision to grant or deny benefits is reviewed pursuant to ERISA, 'a motion for summary judgment is merely the conduit to bring the legal question before the district court.'"

[2] *Reed v. Huntington Ingalls Indus., Inc.*, No. 11–1816, 2012 WL 4460822, at *2 (E.D. La. Sept. 26, 2012).

An administrator's decisions regarding plan terms and eligibility for benefits are subject to *de novo* review in the district court "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."[3] If the plan grants such discretion, the administrator's determinations are reviewed only for abuse of discretion.[4] In the Fifth Circuit, an administrator's factual determinations are always reviewed for abuse of discretion, regardless of whether the plan grants the administrator discretionary authority.[5] The parties concede, and the Court is convinced that, the abuse of discretion standard applies to this matter.

Under this standard, the Court looks to whether the administrator acted arbitrarily or capriciously.[6] "A decision is arbitrary only if 'made without a rational connection between the known facts and the decision or between the found facts and the evidence.'"[7] The Court will uphold the administrator's decision "if it is supported by substantial evidence."[8] The Court's review "need not be particularly complex or technical; it need only assure that the administrator's decision fall somewhere on a continuum of reasonableness—even if on the low end."[9] "A district court may not engage in *de novo* weighing of the

[3] *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989).

[4] *Vercher v. Alexander & Alexander Inc.*, 379 F.3d 222, 226 (5th Cir. 2004).

[5] *Id.*

[6] *Meditrust Fin. Servs. Corp. v.. Sterling Chems., Inc.*, 168 F.3d 211, 214 (5th Cir. 1999).

[7] *Id.* at 215

[8] *Id.*

[9] *Holland v. Int'l Paper Co. Ret. Plan*, 576 F.3d 240, 247 (5th Cir. 2009).

evidence."[10]

LAW AND ANALYSIS

The Court begins its discussion with the issues on which the parties agree. There is no dispute that Plaintiff was entitled to short-term disability benefits as a result of his injury or that Plaintiff was initially entitled to long-term disability benefits. The parties also agree that, under the terms of the plan, Plaintiff was only entitled to long-term disability benefits if "due to sickness, pregnancy or accidental injury, you are receiving Appropriate Care and Treatment from a Doctor on a continuing basis; and . . . you are unable to earn more than 80% of your Predisability Earnings . . . at your Own Occupation[11] for any employer in your Local Economy."[12] Therefore, the sole issue presented is whether, on April 4, 2012, Plaintiff was capable of earning more than 80% of his predisability earnings working as a bodyman. Defendant concluded that he was. This Court must determine whether that decision was arbitrary and capricious.

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[10] *Dramse v. Delta Family-Care Disability and Survivorship Plan*, 269 Fed. Appx. 470, 478 (5th Cir. 2008).

[11] "'Own Occupation' means the activity that you regularly perform and that serves as your source of income. It is not limited to the specific position you held with your Employer. It may be a similar activity that could be performed with your Employer or any other employer." Administrative Record at M-0018. The administrative record for Plaintiff's claim was submitted to the Court manually, thus it does not appear in the electronic Court record. Where the Court cites to the administrative record, it does so using the bates stamped pagination contained in the record.

[12] This definition of disability only applied for the first 24 months that Plaintiff received benefits under the plan. After 24 months, the plan would only pay benefits if Plaintiff was unable to earn more than 60% of his predisability earnings at any occupation in the local economy.

It is helpful to begin with a review of Plaintiff's medical and claim history.

A. Medical and Claims History

On October 14, 2009, Plaintiff experienced severe pain in his abdominal and groin area while at work. He was transported to the hospital where he was diagnosed with an inguinal hernia. Plaintiff underwent surgery to repair the hernia. While the surgery appears to have been successful, Plaintiff continued to experience severe pain in his lower abdomen. When Plaintiff's pain failed to abate, he was referred to Dr. Skaribas, a pain management specialist.

Dr. Skaribas first saw Plaintiff on April 8, 2010. Dr. Skaribas diagnosed Plaintiff with bilateral ilioinguinal neuralgia, or severe nerve pain in the groin area.[13] Plaintiff was prescribed pain medication and scheduled for a nerve block procedure. The nerve block was performed on August 17, 2010, and Plaintiff experienced temporary improvement.

On June 23, 2010, pursuant to a request from Defendant, Plaintiff's employer submitted a form detailing the requirements of a bodyman. The form indicated, as relevant to Plaintiff's claim, that a bodyman was required to occasionally lift up to fifty pounds and was never required to lift more than one hundred pounds. Curiously, Plaintiff's employer did not indicate with what frequency bodymen were required to lift fifty to one hundred pounds.

On March 25, 2011, Dr. Skaribas submitted an "attending physician statement" to Defendant. Dr. Skaribas indicated that Plaintiff was suffering from chronic pain syndrome and ilioinguinal neuralgia and that Plaintiff was

[13] *See* Stedman's Medical Dictionary 199700, 271340 (27th ed. 2000).

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